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## **The profile of absconding psychiatric inpatients in Australia**

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## The profile of absconding psychiatric inpatients in Australia

Eimear Muir-Cochrane, Krista Mosel, Adam Gerace, Adrian Esterman, Len Bowers

### ABSTRACT

**Aims and objectives:** The purpose of this study was to examine absconding behaviour (a patient leaving the hospital without permission) within acute and rehabilitation wards of one Australian psychiatric institution, in order to describe the characteristics of the absconding patient and these events.

**Background:** Absconding is a significant issue within psychiatric inpatient settings, with risks which include patient harm, aggression and violence. In spite of this, limited research has been conducted in Australia on patients who abscond while receiving psychiatric care.

**Design:** The study was a retrospective descriptive analysis.

**Method:** Absconding events from three acute and seven rehabilitation wards over a 12-month period were studied.

**Results:** The rate of absconding events by detained patients was 20.82%. Gender was not significantly associated with absconding, although 61.19% of those who absconded were men diagnosed with schizophrenic disorders. Over half of acute care patients who absconded left during their first 21-day detention order. More than half of absconding events were by patients that absconded more than once. There was limited support for the efficacy of locking ward doors. Age and diagnosis emerged as particularly important factors to consider.

**Discussion:** The study revealed that men are not more likely to abscond than women, that locking ward doors does not deter determined absconders and that once a person

has absconded they are more likely to do so again. Younger patients and those with a schizophrenic disorder may be particularly likely to abscond. There also appears to be a link between continuing detention orders and an absconding event.

**Conclusions:** Findings provide new data about the profile of absconding patients in Australia. Exploration of the reasons why patients abscond, and why many do so repeatedly, warrants further investigation.

**Relevance to clinical practice:** Risk management approaches taking into account factors associated with absconding could be trialled to reduce the incidence of absconding in psychiatric inpatient settings.

**Keywords:** absconding, inpatients, risk assessment, risk management

## INTRODUCTION

In Australia, 45% (7.3 million) of the population aged between 16-85 years have experienced a mental disorder, with 20% (3.2 million) of Australians experiencing symptoms in the previous year (Australian Bureau of Statistics [ABS] 2008). Mental health services, including hospitalisation or consultation with a health professional, were accessed by 35% of these Australians with a disorder in the preceding year (ABS 2008). Over the last 30 years, the process of deinstitutionalisation has resulted in the reduction in the number of inpatient psychiatric wards in Australia and around the world. In Australia, there are on average 10 beds per 100,000 population of public hospital psychiatric beds (Australian Institute of Health and Welfare [AIHW] 2006), usually with 100% occupancy on any given day. This compares with an average of 250 beds per 100,000 population of acute public hospital beds (AIHW 2006). Pressure on inpatient psychiatric services means that only the most severely unwell are admitted for treatment, often those individuals with psychotic disorders and with as many as 50% of these patients held compulsorily under mental health act legislation (Muir-Cochrane & Mosel, 2008). Recently admitted detained patients leaving hospital without permission (absconding) is a cause of serious concern for families and health professionals alike.

### **Absconding**

Significant social, economic, and emotional costs are associated with absconding. A recent systematic review conducted by Muir-Cochrane and Mosel (2008) of literature published between 1996 to 2008 identified 39 articles involving absconding from inpatient psychiatric institutions, with absconding rates (when reported) between 2.5% to 34% of all psychiatric admissions. A significant problem identified within this

research area was the lack of a uniform definition of absconding, as well as differences in the methods of calculating absconding rates. In spite of some of these shortcomings, absconding patients were identified as posing a serious risk to themselves and/or the general public. In addition to harm to self and others (Farragher *et al.* 1996, Walsh *et al.* 1998, Clark *et al.* 1999; Shah & Ganesvaran 2000; Dickens & Campbell 2001, King *et al.* 2001, Bowers 2003, Bowers *et al.* 2003a), additional risks included missed treatment resulting in longer rehabilitation times, as well as cessation of treatment altogether, medication non-compliance and substance use (Manchester *et al.* 1997, Bowers *et al.* 1999a, Bowers 2000).

Although only a limited body of research on the characteristics of those patients who abscond while receiving psychiatric care exists, research which has been conducted – largely originating from the UK – suggests some prevalent characteristics. From this work, patients most likely to abscond are young detained men diagnosed with schizophrenia; with most absconding events occurring within the first three weeks of admission (Bowers *et al.* 1998a, Muir-Cochrane & Mosel, 2008). Within Australia, however, there has been little research conducted, with only five identified Australian articles published between 1996 and 2009 (Manchester *et al.* 1997, Meehan *et al.* 1999, Shah & Ganesvaran 2000, The Joanna Briggs Institute 2007, Carr *et al.* 2008). Of these investigations, only two presented absconding rates (Meehan *et al.* 1999, Carr *et al.* 2008), although one failed to define absconding, and only one of these (Meehan *et al.* 1999) addressed the characteristics of patients who abscond.

Identifying the profile of patients more likely to abscond and the circumstances surrounding absconding events would assist in the assessment and management of the risk associated with absconding behaviours. Risk management is an important tool

within the psychiatric setting in order to protect the welfare of the patient and the community at large. The purpose of the present study, therefore, was to investigate absconding in an Australian psychiatric hospital in order to offer new insights that can inform effective management of acutely ill psychiatric patients.

## METHODS

### Study design

A retrospective descriptive design aimed to identify the rate of absconding from a major Australian psychiatric institution over a 12-month period and to provide a profile of absconding patients. Inpatient data were obtained from two databases maintained by the institution: (a) the inpatient discharge database, containing demographic details as well as information about diagnoses and treatment; (b) a database containing information on each episode of absconding. Under local state legislation, a patient is detained to an approved treatment centre when a medical practitioner is satisfied that this person has a mental illness that requires immediate treatment and the detention is in the interests of the safety of the patient and/or others. This three-day detention order is reviewed within 24 hours of admission and, if the patient is determined as still requiring treatment and further detention, the patient is placed on a 21-day detention order, a period which can be extended by a second 21-day detention order. During this admission, the patient must not leave the approved treatment facility without official approval. For the purposes of this study, only detained patients who abscond are included. Absconding by voluntary patients is recorded only informally and is not included in the database. Data were collected and analysed for the period September 1, 2006 to August 31, 2007. Ethical approval was obtained from the

relevant hospital and university committees, and data was provided to the researchers in non-identifiable form in accordance with the National Statement on Ethical Conduct in Human Research (NHMRC 2007).

### **Details of the institution**

The psychiatric hospital campus consists of acute and extended care (rehabilitation) wards, a closed forensic ward, and a high security closed intensive care unit. Services offered include intensive care, rehabilitation, mental health services for older people, services for rural and remote patients, distance liaison, tele-psychiatry and, forensic services. The hospital campus had approximately 250 beds in 2007-2008 (as some wards or beds closed over time) with over fifty percent of patients being on detention orders under the state Mental Health Act. For the purposes of this research, wards providing mental health services for older people and forensic/high security wards were excluded. This was based on a consideration of the unique characteristics of these patients and wards, which may make the examination of more general trends within the absconding population problematic. As a result, ten wards were included (three acute wards, and seven rehabilitation wards) in analyses. The acute and rehabilitation wards serve distinct geographical locations and admit both detained and voluntary patients. Different ward cultures dictated whether the ward door was locked or unlocked for the duration of the study (i.e. the acuity of patients across the acute care wards was similar).

### **Statistical analysis**



A description of the patients with respect to demographic details, type of admission (voluntary or mandatory detention) and diagnosis is presented. Rates of absconding events and patients are then provided, with an investigation of the relationship between absconding and characteristics of patients and events (when inferential statistical tests are reported, all  $p$  values are at the two-tail level of significance). Finally we compare the profile of absconding patients with non-absconding patients, using CHAID analysis. CHAID is an exploratory technique for investigating large quantities of categorical data and is one of several classification tree-based exploratory methods used to partition or segment a population. The purpose of CHAID is to create homogenous segments of the population based on the value of some outcome or dependent variable (in our case absconding) by splitting the population into two or more groups on the basis of predictor variables. After each split, the resulting groups are evaluated separately to see if a further split on any of the predictor variables would create significantly more homogenous groups. When it is no longer possible to make the resulting groups more homogenous the program halts. The segments derived by CHAID are mutually exclusive and exhaustive which means, that the segments do not overlap and each person in the population belongs to exactly one segment. The statistical package CHAID for Windows version 6 was used for this analysis. All other analyses were conducted in SPSS for Windows version 16.

There are often inconsistencies in the ways in which absconding events and patients are described in the research, leading to incomparability of results between studies and a lack of precision (Bowers 2000). In the case of absconding rates, there are issues with both the numerator (i.e. number absconding) and the denominator (i.e. number at risk of absconding); thus it is important to make clear whether *event-based* or

*patient-based* calculations are used (Bowers 2000). When using event-based data, repeat absconding incidents by patients are distributed across the total number of patients, resulting in higher rates. Both patient-based and event-based rates of absconding are reported here.

## RESULTS

### Description of inpatients

During the period of data collection, there were 457 male and 229 female acute and extended care patients in the included wards. Of these patients, 538 (377 men, 161 women) were detained ( $M=36.63$ ;  $SD=11.19$ ;  $Range=18-67$  years). Detained male patients ( $M=35.75$ ,  $SE=.56$ ) were significantly younger than female detained patients ( $M=38.70$ ;  $SE=.92$ ),  $t(536) = 2.82$ ,  $p = .005$  (95% CI .90 to 5.01). Of detained patients, 68.03% were Caucasian, 7.62% were Aboriginal and/or Torres Strait Islander, 1.67% were Asian, and 2.23% were Other. Information on ethnicity was not available for 20.45% of the detained sample, probably due to nursing staff not being required to collect this data by the organisation.

The major principal diagnoses of detained patients were as follows: 68.03% schizophrenic disorders, 9.48% bipolar disorders, and 8.74% depressive disorders. The median length of stay overall was 25 days. However, the median length of stay for acute care patients was 22 days.

### Rate of absconding

The absconding event-based rate per 100 detained patients was 20.82%, with 112 events recorded. Men were responsible for 73.21% of events. Table 1 presents

event-based rates for the total detained sample, and separately for men and women. In all absconding events, the patient returned to the ward, and in 64.29% of events (72 out of 112 abscond events), the patient returned to the ward within 24 hours. There were no deaths occurring during the period the patients were away from the ward.

< Insert Table 1 about here >

Of the 112 absconding events recorded over the 12-month period, 67 patients (50 men, 17 women) were responsible for those events (12.45% of detained patients). Gender was not significantly related to absconding,  $\chi^2(1, N = 538) = .76, p = .384$  (risk ratio = 1.26 (95% CI .73 to 2.23)). Table 2 presents the patient-based absconding rates for the total sample and separately for men and women. Another way to examine the relationship between gender and absconding is by events. Based on the proportion of detained men (70.07%) and women (29.93%) in the studied wards, it is expected that men would be responsible for more events (78.48) than women (33.52). A chi-square test of independence reveals that the observed number of events for men and women is not significantly different when taking this into account,  $\chi^2(1, N = 112) = .53, p = .467$ .

<Insert Table 2 about here>

Absconding patients were significantly younger ( $M=33.99, SE=1.33$ ) than those detained patients who did not abscond ( $M=37.01, SE=.52$ ),  $t(536) = -2.07, p = .039$  (95% CI -5.88 to -.16). A majority of absconding patients (79.10%,  $N=53/67$ , with

diagnosis information not available for two patients) had a principal diagnosis of a schizophrenic disorder, and absconding was statistically significantly related to having a schizophrenic disorder,  $\chi^2(1, N = 535) = 5.90, p = .015$  (risk ratio = 2.04 (95% CI 1.12 to 3.98)). Forty-one of these patients with a schizophrenic disorder were men (61.19% of all absconders); however, absconding male patients were not more likely to have a schizophrenic disorder than absconding female patients, *Fisher's exact test* = .273 ( $N=65$ ) (risk ratio = 1.21 (95% CI .65 to 2.39)).

### **Patients that abscond more than once**

Out of 112 absconding events in this 12 month period, 63 events (56.25%) were by patients who had absconded more than once. These events involved 19 repeat absconders ( $M=29.79$  years,  $SE=1.42$ ), 15 (78.95%) of whom were men. Repeat absconders were significantly younger than non-repeat absconders ( $M=35.36$ ,  $SE=1.67$ ),  $t(60.04) = -2.54, p = .014$  (95% CI -9.96 to -1.19). Repeat absconders accounted for 31.34% of absconding patients, and these patients absconded between two and nine times (see Table 3).

<Insert Table 3 about here>

### **Legal Status**

On the acute wards, 59.18% ( $n=29/49$ ) of absconding patients left during their first 21-day detention order; 20.41% ( $n=10/49$ ) left during their second 21-day detention order. The remaining 20.41% of absconding patients were on another type of detention order (3-day, continued, forensic).

### Locking doors

All absconding events from both the acute and rehabilitation wards were examined on a ward by ward basis to establish the effectiveness of locking doors in preventing absconding events. Interestingly, the greatest number of absconds ( $N=38$ ) occurred from a locked acute ward. Table 4 presents the number of absconding events by ward exit security for those wards which recorded an absconscion. Overall, 55 absconding events occurred in open wards, and 57 events in closed wards. Based on the proportions of detained patients in open (286, 53.16%) and closed wards (252, 46.84%), the difference in absconding events is not significant,  $\chi^2(1, N = 112) = .74, p = .390$ . In terms of patient-based calculations, 35 absconding patients were from closed wards, while 32 absconding patients were from open wards, with absconding not related to whether the door was locked,  $\chi^2(1, N = 538) = .90, p = .344$  (risk ratio = 1.24 (95% CI .77 to 2.02)).

### Profiling absconding patients

In addition to investigating characteristics associated with absconding (above), it is also important to develop a profile of the absconding patient which considers multiple characteristics. CHAID analysis was undertaken on the sample of detained hospital patients, comparing those patients who did ( $N=65$ ) and did not ( $N=470$ ) abscond (with the three patients who did not have a recorded principal condition excluded from analysis). Figure 1 presents the results of this analysis. Age was the first predictor to emerge, with 16.80% of patients under 35 years of age leaving the hospital, and 10.69% of patients between 35-44 years absconding. Thus, 89.23% of all absconding patients

were 44 years of age or younger. For patients under 35 years, diagnosis emerged as the next predictor of absconding, with 20.71% ( $N=35$ ) of patients with a schizophrenic disorder absconding; the other diagnoses of those who absconded in this age group were depressive disorder ( $N=1$ ), bipolar disorder ( $N=3$ ), or unspecified nonorganic psychosis ( $N=2$ ). For patients 50 years and over, gender was the next predictor, with 11.90% ( $N=5$ ) of these men absconding, and 3.13% of women. Ward exit security did not emerge as a predictor of absconding.

<Insert Figure 1 about here>

## DISCUSSION

This study investigated how many patients of psychiatric services absconded from a large hospital campus over 12 months, as well as examining patient and event characteristics associated with this behaviour. The calculated rate of absconding in the current research is higher than that of a number of other studies (Pages *et al.* 1998, Meehan *et al.* 1999, Dickens & Campbell 2001, Bowers *et al.* 2003b, Carr *et al.* 2008, Khisty *et al.* 2008). While more men absconded and were responsible for more events than women, gender was not significantly associated with absconding. Similarly, while having being diagnosed with a schizophrenic disorder was associated with an increased probability of absconding, there was also a lack of a gender difference in this relationship. Exit security of the ward did not emerge as a significant predictor of absconding from the ward, although based on the number of patients in open and locked wards, locked wards were the site of slightly more absconds. For patients in acute care wards, a first 21-day detention order was a time of increased absconding. Overall, when

considering the absconding patient, age and diagnosis figured prominently in the profile of the patient who absconds.

The data confirms the findings of other studies in relation to absconding patients; that is, generally young men diagnosed with some form of schizophrenia (Farragher *et al.* 1996, Quinsey *et al.* 1997, Bowers *et al.* 1999b, Meehan *et al.* 1999, Bowers *et al.* 2000, Bowers *et al.* 2003a, The Joanna Briggs Institute 2007), although this study found that women were also represented in the absconding population. Meehan *et al.* (1999) have argued that young male schizophrenic patients are more likely to be admitted to inpatient facilities, which leads to an overrepresentation when constructing a statistical profile. Indeed, the present study considered the number of patients with a schizophrenic disorder who absconded in comparison to non-absconding detained patients with one of these disorders, finding a significant relationship between these disorders and leaving the hospital. Men who absconded, however, were not more likely to have a schizophrenic disorder than women who left the ward, although the small sample size for such a gender comparison (and low expected values in each cell) warrants further investigation of this issue with larger numbers of patients. While the relationship between gender and diagnosis in relation to absconding is therefore complex, the number of men with schizophrenia and their predilection to abscond suggests particular attention to this group, although the present findings stress the need to also consider more generally those with a schizophrenic disorder regardless of gender.

Sixty-three absconding events were accounted for by less than 30% of the absconding sample. This is higher than rates reported by Meehan *et al.* (1999), who found that over one third of all absconding incidences were by the same individuals. In

the present study, there was a small sub-group of patients that accounted for over half of all absconding incidences. The findings of the present study suggest that once a patient absconds, the risk of that patient absconding again is increased and may serve as a predictor of absconding. However there is limited research published to date that has investigated the characteristics of this small group of patients and the reasons as to what compels them to leave repeatedly. In the present study, these patients were found to be younger than those patients who absconded once, with the majority men (for similar findings see Bowers *et al.* 1998b). Evidently, increased research attention on this group is warranted.

There has also been little research investigating the length of time a detained patient will stay in the hospital before absconding. The present study has found that patients detained under a 21-day detention order (after an initial 3-day detention order) are at particular risk to abscond. This suggests the importance of particular attention to the needs of the patient once their detention for additional psychiatric care has been instated. Bowers *et al.* (2005), for example, has stressed the need for careful communication of unwelcome or bad news.

One common intervention to reduce absconding is to lock the doors to a ward, although effectiveness of this practice has not been established, and staff are reluctant to participate (Bowers 2003). The consequence of this is also an over-restriction of all inpatients, due to the actions of a few (Dickens & Campbell 2001). Physical containment measures do not seem to be sufficient to reduce absconding, with Manchester *et al.* (1997) demonstrating that absconding is often the outcome of the interaction between precipitating environmental factors, organic variables and psychological traits. The findings in the current study indicate that although there



tended to be an overrepresentation of absconding patients in locked wards, the difference was not significant. This is indicative that locking the ward door will not necessarily serve as a deterrent for the patient who wishes to leave.

The CHAID analysis which attempted to form a profile of the absconding patient consisting of multiple characteristics augments the findings of these analyses. The strongest predictor of absconding was age, with younger patients more likely to abscond. Certainly, in the present study absconding patients, as a whole, were significantly younger than those patients who did not abscond. Within the youngest group (<35 years), diagnosis emerged as a variable to pay particular attention, with those with a schizophrenic disorder more likely to abscond. While there were not many absconding patients who were 45 years or older, 9.23% of the absconders were at least 50 years of age, indicating some attention to the older consumer who absconds is needed.

### **Limitations**

There are some limitations within the current study. This hospital only records absconding by detained patients and therefore there is no information for patients not under detention orders but who leave the hospital without formal approval. Currently within Australia, if voluntary patients leave without permission, they may be placed on leave when it is discovered they have left the ward, they may be discharged, or their bed may be kept open to allow them to return of their own volition. As these decisions are made variously across individual wards and data about voluntary patients absconding are not collected routinely, it becomes difficult to examine such absconding in any meaningful way. Furthermore, published literature to date has often investigated

absconding by both voluntary *and* involuntary patients. As a result, comparisons are difficult to make. However voluntary patients who choose to leave hospital are an important cohort to study, and examining their reasons for leaving and the effect on their treatment and recovery would allow comparisons within a wider setting to be made. In addition, separating these two types of patient in analysis (which most previous work has not done) is likely to be useful in order to examine similarities and differences. Finally, while the present study examined absconding within a large psychiatric hospital campus consisting of several wards, it would be useful for future work to examine absconding behaviour in other psychiatric settings, such as those located within a general hospital service.

### **RELEVANCE TO CLINICAL PRACTICE**

The present study contributes to an understanding of patient variables associated with leaving the hospital ward without permission. In doing so, factors of which mental health nurses and other health professionals should be particularly aware in assessment and care planning become apparent. Findings regarding differences in age and diagnosis should be considered alongside predictors which had less of an influence in this study, such as gender. That locking doors seems to have a weak effect on preventing absconding, while the importance of other variables such as detention order emerge indicates the importance of a move away from restrictive measures to a greater consideration of a patient's experience of admission and hospitalization (Bowers, 2003, Cleary *et al.* 2009). In addition, environmental factors associated with absconding, for example staffing levels and time of day when more absconds occur, are important to

consider (Muir-Cochrane & Mosel 2008). In doing so, the potential for practical interventions to reduce absconding becomes apparent (see Bowers *et al.* 2003a).

## CONCLUSION

In this study, approximately one in ten patients was found to abscond at least once during their treatment in the studied psychiatric facility. This indicates that absconding is a problem of sufficient prevalence to warrant greater attention. This research has demonstrated that men are not necessarily more likely to abscond than women based on how many men and women are under psychiatric care, although they are responsible for more events and a larger number of them abscond. Age and a diagnosis of schizophrenic disorder emerged as particularly important predictors of absconding. The locking of ward doors does not deter the determined absconder, and may possibly serve to restrict the greater inpatient population. Finally, once patients abscond, there is an increase in likelihood that they will do so again. This would be worthy of further investigation. This work adds to the literature documenting absconding, particularly in Australia. In addition, other factors that need be considered have been identified by Muir-Cochrane and Mosel (2008), who suggested that future work should examine ‘the psychological profile and characteristics of the individual inpatient, the meaning of the admission, alienation, social structure of the unit, situational and environmental factors, and precipitating events’ (p. 376).

## CONTRIBUTIONS:

Study Design: EM-C, AE, LB

Data Collection and analysis: EM-C, KM, AG, AE

Manuscript preparation: EM-C, KM, AG, AE, LB

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## **CONFLICT OF INTEREST**

None

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*Figure 1.* CHAID analysis comparing absconding patients with those detained patients who did not abscond.

*Note:* *N* refers to total number of patients in the category. % refers to patients absconding within each category. Schizophr Disorder = Schizophrenic Disorder. Non-organic psychosis = unspecified non-organic psychosis; Substance use = mental and behavioural disorders due to psychoactive substance use

Table 1

*Absconding event-based rates, by gender*

	Absconding events	Hospital detained discharges	Absconding rate
Male	82	377	21.75%
Female	30	161	18.63%
Total	112	538	20.82%

Table 2

*Absconding patient-based rates, by gender*

	Absconding patients	Hospital detained discharges	Absconding rate
Male	50	377	13.26%
Female	17	161	10.56%
Total	67	538	12.45%



Table 3

*Number of events by absconding patients*

Number of absconding events	Absconding patients	% of absconders	% of repeat absconders
One	46	68.66	-
Two	8	11.94	42.11
Three	8	11.94	42.11
Four	-	-	-
Five	1	1.49	5.26
Six	2	2.99	10.53
Seven	-	-	-
Eight	-	-	-
Nine	1	1.49	5.26
Total	67	100	100

Table 4.

*Number of absconding events by ward exit security*

	Locked		Unlocked	
	Wards	Events	Wards	Events
Acute Care	1	38	2	26
Extended Care	1	19	4	29
Total	2	57	6	55



